## AGREEMENT FOR MEDICAL CONSULTING SERVICES

I (and anyone who is legally authorized to make decisions concerning my health on my behalf) agree to allow Medical Empowerment LLC to review my medical records and to provide the services listed below (in aggregate or in part) or other services as mutually agreed upon between Medical Empowerment LLC and me:

* An assessment of my serious neurologic illness and formulation of individualized recommendations and options for my consideration
* Discussing with me about my serious neurologic illness
* With my authorization, reviewing my medical records
* Advising on how I may communicate with my health care providers and suggesting insightful questions to ask my health care providers with the goal of having my medical appointments be productive, efficient and effective
* Providing a clear, plain-language description of medical information received from my health care providers
* Discussing with me the medications I currently take and treatment options for my medical conditions, which may include information about medications or gene therapies that may be appropriate for my medical conditions and/or clinical trials that I may be eligible for
* Discussing options by which I might be able to slow disease progression, manage my symptoms, or improve quality of my life for my serious neurologic illness
* Providing relevant verbal and written educational materials
* Reviewing the selection of additional health care specialists who can assist with my medical care
* When authorized by me, discussing the above items with family members or my other representatives

I understand that neither Medical Empowerment LLC nor Dr. Martin Bednar is my health care provider and that neither will provide any direct patient care or other medical services to me. The following is a non-inclusive list of the services that will not be provided by Medical Empowerment LLC or Dr. Bednar:

* Performing any physical or medical examinations
* Diagnosis of any medical condition
* Treatment for any medical condition, including but not limited to, prescribing medications of any kind, refilling medications or advising on dosage of medications
* Discussing my medical condition directly with my health care providers
* Obtaining medical records directly from health care providers
* Arranging for medical appointments, tests or treatment
* Attending appointments, tests or treatment with health care providers
* Hiring or managing direct caregivers
* Psychiatric care or counseling
* Transportation services
* Home visits
* Enrolling in Medicare, Medicaid or private insurance coverage
* Assisting with insurance claims, finding or obtaining financial resources, handling payment issues with health care providers and/or insurers or filling out forms for health care providers or insurers
* Emergency/immediate interaction for any medical illness

At no time will Medical Empowerment LLC interfere with my relationship with my physicians or other health care providers. Medical Empowerment LLC will confer with my health care providers only with my prior written consent.

I agree to pay the fees for services received as outlined in Attachment A, “Fees and Payment Information.”

Dr. Bednar’s Connecticut and Massachusetts physician license numbers are included on the signature page. Please note that Dr. Bednar is retired from the practice of medicine.

Medical Empowerment LLC offers services using telecommunications platforms (including audio- only telephone) that are designed to protect my privacy. The laws that protect the privacy and confidentiality of my medical information also apply to services rendered through these telecommunications. Risks associated with the use of telecommunications include, but are not limited to, technical difficulties or interruptions, distortion of images or loss of information due to technical failures and failure of security protocols resulting in unauthorized access to my health care information. I understand that I should be in a private place during the provision of telecommunications services so that other people cannot hear me, and that I should use a network that is private and secure. I understand that information provided via telecommunications is not recorded or saved.

Under no circumstances should any discussion between me or any individual involved on my behalf and Dr. Bednar be recorded. I agree to disable the recording option upon logging on for any interaction with Dr. Bednar.

Please read the following disclosures carefully. If you have any questions, you may email Medical Empowerment LLC at mmbednar@mymedicalquestionsanswered.com.

Medical Empowerment LLC provides general information and guidance, but does not provide medical, insurance or legal advice of any kind. I understand that I should seek medical advice from

one or more duly licensed health care providers before making any decisions related to my medical care. By signing this document, I acknowledge that any decision regarding my health must be made by me, and not by Medical Empowerment LLC. While Medical Empowerment LLC strives to assist in helping me to identify only providers of high-quality services that I may decide to involve in my health care, it cannot warrant and does not assume liability for the actions of other health care providers that may be referred by it. Specific medical outcomes cannot be guaranteed. I agree to hold Medical Empowerment LLC and Dr. Martin Bednar harmless from any decision that I make or action that I take in connection with or as a result of any information I receive from Medical Empowerment LLC, its website, or any materials provided by it.

I acknowledge that I have read and understand the foregoing Agreement, and I have had the opportunity to ask questions. I consent to receive consultation services about my health from Medical Empowerment LLC.

Signature: Date: Printed Name:

Signature of Legal Representative: Date: (if applicable)

Printed Name:

Medical Empowerment LLC

By: Date: Martin M. Bednar, M.D., Ph.D., FAANS

CT License # 38788 MA License # 281666

## ATTACHMENT A FEES AND PAYMENT INFORMATION

I understand the following:

* The first meeting will last approximately one hour and the fee is a flat rate of $275.00.
* The fees for any subsequent meetings will be charged at the rate of $200/hour, which will be prorated for shorter meetings (e.g., $100 for a 30-minute meeting; $50 for a 15-minute meeting).
* I will be informed in advance of any rate increases.
* Medical Empowerment LLC accepts payment by credit card. Clients are required to keep current credit card information on file for the following reasons: session payments, missed appointments and/or late cancellations. All credit card information is securely stored.
* Medical Empowerment LLC does not accept Medicare, Medicaid or any private insurance, and I understand that the company is making no representation that its services would be covered under any insurance plan.
* Charges are final unless an error or unauthorized charge occurs. I agree to resolve any disputes directly with Medical Empowerment LLC before initiating a chargeback or dispute through my bank or credit card company.
* I may be responsible for the full cost of any missed or canceled session if I have not provided Medical Empowerment LLC with notice at least 48 hours prior to the scheduled appointment time. In case of emergency or illness, I agree to contact Medical Empowerment LLC as early as I am able to potentially make alternate arrangements. Such cases will be considered on an individual basis and treated appropriately.
* If I am late for my scheduled start time by more than 15 minutes, Dr. Bednar may not be able to see me for my session. I understand that I may be responsible for a late fee up to the full cost of the scheduled session.

Please fill out the information below:

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| --- | --- |
| Name on Credit Card |  |
| Card Type (e.g., Visa, Master Card, Discover.American Express) |  |
| Credit Card Number |  |

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| Expiration Date |  |
| Security Code |  |
| Billing Zip Code |  |

I hereby authorize Medical Empowerment LLC to charge my credit card for services rendered. I agree that any fees for services rendered will be charged to the above credit card. My credit card may also be charged fees for missed appointments or late cancellations. I agree to notify Medical Empowerment LLC in writing of any changes to the information on this form promptly so that there is no lapse in payment.

Authorized Payer's Name: Relationship to Client: Phone Number:

Email: Signature: Date:

I have read and understand the terms of the Fees and Payment Information. I authorize Medical Empowerment LLC to charge my selected payment method as outlined above. I confirm that I am the authorized user of the account.

Signature:

Printed Name:

Date:

Signature of Legal Representative: Date: (if applicable)

Printed Name:

# HEALTH QUESTIONNAIRE

Please complete the Health Questionnaire below. Our first meeting will consist of a discussion of your responses to this Health Questionnaire and your concerns and questions about your health.

[Please see separate Questionnaire]

### HEALTH ASSESSMENT FORM

**Name** **Date**

|  |  |
| --- | --- |
| Date of Birth Address Medical Record # (office to complete):**Who is your Primary Care Physician?**Address Phone #  | Phone (home) Phone (work) Phone (cell) Email Person completing this form: |

**What is the problem for which you are being seen (chief complaint)?**

**What tests have been done?**

**Have you seen other doctors for this problem (please list)?**

**PAST MEDICAL HISTORY: Please list all medical problems and surgeries you have had (including cataract surgery, biopsies, and skin procedures).**

|  |  |  |
| --- | --- | --- |
| **Active Medical Problems** | **Old Medical Problems** | **Surgeries (Dates)** |
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### SOCIAL HISTORY

Are you:

* Single
* Married
* Divorced
* Widowed

Do you have children?:

* Yes
* No

If yes, how many and how old?:

Are you presently employed?: completed)

* Yes
* No

Grade level of education (last year

Occupation(s):

Year of retirement (if applicable) Year disabled (if applicable)

**Do you smoke?:**

* Never Used
* Yes
* Quit

If quit, when?:

When did you first start smoking?: How much per day do you smoke?

**Do you drink Alcohol/Wine/Beer?:**

* Never Used ☐ Yes ☐ Quit If quit, when?:

If yes, how often?:

* Daily
* More than 3 times per week
* Less than 3 times per week

If yes, how much?:

2

**Have you used recreational drugs?:**

* No
* Yes

If yes, what drugs and when?:

**Do you regularly exercise?:**

* No
* Yes

If

yes,

what

type

and

how

often?:

**Are you on any type of special diet?:**

* No
* Yes

If yes, what type?:

### FAMILY HISTORY

Please list any major medical problems in your relatives (especially any neurologic conditions, diabetes, heart disease, high blood pressure and cancer):

Mother: Father: Brothers/Sisters: Your children (if applicable):

Are there any other important medical conditions in other relatives? If yes, please list:

3

#### REVIEW OF SYSTEMS: Please CHECK if you have any of these symptoms currently.

**Constitutional Respiratory Neurologic**

❑ Fever / Chills / Sweats ❑ Cough ❑ Headache

❑ Weight Loss ❑ Phlegm ❑ Numbness or Tingling

❑ Tiredness / Fatigue ❑ Coughing up blood ❑ Muscle weakness

❑ Poor Appetite ❑ Wheezing / Asthma ❑ Loss of consciousness

**Eyes Gastrointestinal** ❑ Memory or thinking problems

❑ Reduced vision or blurriness ❑ Abdominal pain ❑ Trouble with walking or balance

❑ Double vision ❑ Nausea and / or vomiting ❑ Stroke

❑ Droopy eye lids ❑ Vomiting up blood ❑ Seizure

❑ Cataracts ❑ Change in bowel movements **Psychiatric**

❑ Glaucoma ❑ Diarrhea ❑ Psychological or Psychiatric care

**Ears / Mouth / Nose / Throat** ❑ Constipation ❑ Depression

❑ Hearing loss **Genitourinary** ❑ Hallucinations

❑ Ringing in the ears ❑ Pain with urination ❑ Anxiety

❑ Vertigo ❑ Excessive urination ❑ Suicidal thoughts

❑ Hoarseness ❑ Incontinence **Endocrine**

❑ Sinus pain ❑ Blood in the urine ❑ Hot / cold intolerance

❑ Swallowing problem ❑ Sexual problems ❑ Thyroid problems

**Cardiovascular** ❑ Prostate problems ❑ Diabetes or sugar problem

❑ Chest pain / Angina **Musculoskeletal Hematologic / Lymphatic**

❑ Palpitations ❑ Neck or back pain ❑ Anemia

❑ Shortness of breath lying flat ❑ Muscle pain ❑ Easy bruising

❑ Pain in the legs with walking ❑ Pain / redness / swelling of a joint ❑ Enlarged lymph nodes

❑ Phlebitis **Skin Allergic / Immunologic**

❑ Heart attack ❑ Rash ❑ Severe allergic reaction

❑ High blood pressure ❑ Change in sweating ❑ Frequent infections

❑ High cholesterol / lipids ❑ Burns

4

**Do you have difficulties with any of the following activities?** (Please CHECK all that apply)

❑

❑

Bathing

❑ Driving

❑Cleaning/Housekeeping/Laundry

Toileting

❑ Dressing

❑ Shopping

❑

Eating

❑ Taking medications

❑ Using the phone

❑

Paying Bills/Money Management

❑ Cooking ❑ Traveling

**Have you used the following services in the past three months?** (Please CHECK all that apply)

❑

❑

❑

Visiting Nurse

❑ Home health services

❑ Day Program

Physical Therapy

❑ Meal Program

❑ Mental Health Services

Occupational Therapy

❑ Speech Therapy

❑ Other

# THANK YOU FOR COMPLETING THIS FORM

5

## CURRENT MEDICATIONS

Current Medications as of

Client Name:

Date of Birth:

Allergies:

Pharmacy: Pharmacy Phone Number:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date****Started** | **Medication Name** | **Dose** | **How administered****(e.g., oral, IV, IM)** | **Frequency** | **Reason for Taking** |
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## CONSENT FOR RELEASE OF INFORMATION

I authorize Medical Empowerment LLC to access and review my health records. In addition, I authorize Medical Empowerment LLC to receive information from, and discuss my health with, the following individual(s):

Name: Relationship:

Name: Relationship :

My Signature: Date: Printed Name:

Signature of Legal Representative: Date: (if applicable)

Printed Name:

## MANDATORY REPORTING OF SUSPECTED ABUSE

In accordance with professional ethics and mandatory reporting laws, Medical Empowerment LLC is obliged to report all incidents of suspected abuse, neglect, abandonment or exploitation uncovered during the course of its work with elderly clients, clients with intellectual disabilities and clients who receive services from the Connecticut Department of Social Services' Division of Autism Spectrum Disorder Services.